TESTIMONY OF DIANNE ANDERSON, PRESIDENT AND CEO of LAWRENCE GENERAL HOSPITAL

Good afternoon. My name is Dianne Anderson. As the President and CEO of Lawrence General Hospital, I welcome this opportunity and am proud to tell our important story about access, cost and quality. Thank you Commissioner Morales, Attorney General Coakley and her team for putting these hearings and panel together.

- LGH is the "best kept secret" in the Merrimack Valley. We are a comprehensive community hospital- about 200 beds - with an ED that sees 78,000 visits per year, making it the 3rd busiest in the State. We have some unique features, such as an accredited Trauma program, and a nationally known family practice residency. We are a "natural medical home" for a large population in the City of Lawrence- the poorest community in the State- and an example of high access, high quality and low cost care.

- However, it is not sustainable long term with our current private and government payer rates.

- Lawrence General Hospital is a disproportionate share hospital that serves a largely Latino population. We have the highest proportion of Medicaid patients of any community hospital, and the 2nd highest proportion of Medicaid inpatients in the State. Private payers make up only 24% of our revenue so we do not have the same leverage to negotiate the same rates as other hospitals are paid.

- We are a case study for the Attorney General's finding that insurers pay substantially lower rates to hospitals like Lawrence General.

- At the same time, Medicaid, which accounts for 34% of our gross revenue, pays us less than 70% of our costs, and in the past two years has cut:
    - All support for our 24 resident family practice residency program that was created to ensure primary care access for Medicaid patients;
    - Our longstanding Medicaid high public payer reimbursement; and
    - Our Medicaid Outpatient rates by 10%

- Even our Medicaid inpatient rates are only 3% higher today than they were five years ago.

- We are nimble, but there is no more low hanging fruit. Our low rates do not allow us to invest in our physical plant, new capital equipment or IT infrastructure. As a result, our hospital buildings are on average 50 years old, and need desperately to be replaced. Our IT infrastructure requires significant investment to meet state mandates. And we pay a premium to borrow because the markets look unfavorably on our reliance on government payers.

- We cannot compete with much better financed hospitals for privately insured patients. And our ability to provide the care our community and patients deserve – in the long term – is threatened.

- We face the same pressures on wages, medical malpractice, and capital equipment, as every other hospital in Massachusetts, and then some. Our patients require additional services such as interpreters, financial counseling, and dedicated bilingual, bicultural primary care providers.

- In fact, we created a national model for training these primary caregivers with our family practice residency. Sadly this program which now receives no funding at all from Medicaid, is threatened. And its closure would further diminish the State's inadequate supply of primary care doctors.

- In recent months, the State, experimenting with a new health plan, Celticare, and its selected provider network, - redirected legal immigrants who relied on us as a medical home, to a hospital outside of Lawrence. To harness the clout necessary to maintain continuity of care for this population and maintain access in Lawrence, we needed our legislative delegation, as well as the press to tell our story and be part of this narrow Celticare network.

- This flies in the face of the goals for Healthcare reform as I understand them -- high access, low cost and high quality.

- The Celticare experience was a warning to us and should be a red flag to others that market clout and leverage will determine network development in selective contracting, in the same way it does now over pricing. Larger systems will have the market power to dominate, and sideline high value providers like us.

- Lawrence deserves access high quality and high value care in their backyard and should be part of the value equation and solution for ratcheting down spiraling health care costs.

- As President and CEO of this institution, a role which I have been in for only 7 months, it is confounding that neither market forces nor policy in Massachusetts drives more patients to choose high value hospitals like Lawrence for their care.

- Medicaid rates need to be trued up to cost. And private payers need to pay providers without market clout significantly enhanced rates.

- The inequities in pricing that exist today **demand** that mechanisms be put in place, such as those envisioned in Chapter 118G, to ensure that safety net providers thrive and succeed so that the special populations they serve maintain access to care.

- The attorney general's report showed there are inequities in payment rates from insurers. We believe that our hospital, LGH, deserves to be reimbursed at equitable rates for

equitable care. We want to hold ourselves accountable for quality outcomes - but we do need to be reimbursed adequately and fairly for the care we provide.

- I spent most of my career in academic medical centers and want to acknowledge their unique and vital role. I appreciate their unique challenges and the world class care and research they provide. That is their role and we need them. However, I feel that there is a vital need for strong, vibrant community hospitals and providers to provide outstanding, efficient care in the local communities. Together we can provide a coherent, streamlined approach to care that is affordable, but only if the playing ground is made level in terms of reimbursement.

- Thank you for this opportunity to tell our story.

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